[redacted]
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22 May 2012

The Hon Mr Lawrence Springborg, MP
Minister for Health
GPO Box 48
Brisbane Qld 4000

via email: health@ministerial.qld.gov.au
(Original via post)

Dear Mr Springborg

OPEN LETTER OBJECTING TO THE DEFUNDING OF QUEENSLAND ASSOCIATION FOR HEALTHY COMMUNITIES ('QAHC')

It was with disappointment that I read your media statement dated 20 May 2012 concerning the immediate re-direction of funding away from QAHC to an as yet undetermined Ministerial Advisory Committee to guide HIV/AIDS prevention and awareness strategies.[1]

QAHC is a respected and trusted provider of HIV awareness and prevention services, as well as wider health and well-being resources, for the lesbian, gay, bisexual and transgendered ('LGBT') community in Queensland. The importance of community organisations in HIV awareness is paramount. HIV awareness should be presented in the context of one's environment, and thus must take into account factors such as drugs and alcohol, mental health, stigma and discrimination which contribute to such an environment – factors which QAHC take into account in their holistic approach to LGBT health and well-being.

Whilst HIV/AIDS prevention is a critical public health issue and worthy of your immediate attention as Health Minister given increasing notification rates, I believe your method in doing so via defunding QAHC has been made in haste, without basis and possibly for politically motivated reasons.

1. Your media statement

Whilst hopeful it is not your intention, a number of the points you make in your media statement may inadvertently mislead the public. I've taken this opportunity to highlight some of these, and for convenience have also referenced and attached as exhibits supporting evidence.

1.1 'Annual HIV rates have doubled in the last decade: from 2.7 per 100,000 population in 2000, to 5.4 in 2010'

Queensland Health releases an annual report to identify trends in HIV and AIDS notifications over time.[2] The report depicts notification rates of HIV diagnosis by year, and includes a breakdown of

[1] Available from http://statements.cabinet.qld.gov.au/MMS/StatementDisplaySingle.aspx?id=79275.

whether the diagnosis first occurred in Queensland or overseas[3], and also provides a combined total first diagnosis.[4] This has been extracted in Exhibit 1.

As is evident in Exhibit 1 (red highlights), 2.7 per 100,000 in 2000 refers to only where the first diagnosis was in Queensland, whereas 5.4 per 100,000 in 2010 refers to total first diagnosis. It would appear that in your statement, you are not comparing like with like.

1.2 'The diagnosis rates represent the highest level since figures became available in 1984'

Once again, Exhibit 1 (green highlights) evidences the inaccuracy of your claim, as 1985 was in fact the highest rate of notifications, at 5.9 per 100,000. When taking into account Queensland as the first point of diagnosis, three separate years have experienced higher notification rates.

1.3 'I refuse to throw good money after bad and I refuse to turn a blind eye to what are obviously ineffective campaigns at reducing HIV diagnosis rates'

In 2003/04, QAHC (or the Queensland AIDS Council as it then was), won the tender from Queensland Health for HIV prevention for gay men and Aboriginal and Torres Strait Islanders, however lost the tender for HIV care and support services.[5] Given this press release announces QAHC is to be completely defunded, one questions the evidence you have to insinuate QAHC have been running 'ineffective campaigns' for gay men and Aboriginal and Torres Strait Islanders.

Gay Men

Exhibit 2 (red highlights) shows that men who have sex with men has reduced from 73.5% of all Qld HIV notifications in 2005 to 63.1% in 2010.

Aboriginal and Torres Strait Islanders

Exhibit 3 shows that the HIV notification rate of those of indigenous people has reduced from 4.9 per 100,000 in 2005 to 4.5 per 100,000 in 2010, and the HIV notification rate of indigenous men has reduced from 8.5 per 100,000 in 2005 to 6.4 per 100,000 in 2010.

Other risk exposures

Exhibit 2 (green highlights) highlights that heterosexual and persons originating from a high risk country are both areas of risk exposure which have increased in proportion over the 2005-2010 period.

1.4 'QAHC ... has published its intention to move the core of its activity away from AIDS/HIV to more general, political issues'

QAHC's Values Statement is 'Healthy Communities values the *health and wellbeing* of lesbian, gay, bisexual and transgender people and the pursuit of excellence in professionalism, quality, ethics and service delivery.'[6] It's first identified strategic direction is 'Quality & Effective Services – Continue to

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[2] Queensland Government (Queensland Health), *2010 HIV/AIDS Report: Epidemiology and Surveillance* (September 2011). <http://www.health.qld.gov.au/sexhealth/documents/hivaidsannualreport.pdf>

[3] 'Overseas' refers to where the first diagnosis was overseas, but the first diagnosis in Australia was in Queensland.

[44] Queensland Government (Queensland Health), above n 2, 28.

[5] QAHC Press Release, *Funding Cut to Queensland's only LGBT Health Organisation*, 20 May 2012. <http://www.qahc.org.au/files/shared/docs/Media_Release_-_domestic_0.pdf>

[6] QAHC, *Strategic Plan 2012-2015* (2012) 4.

provide quality and effective services that meet *the health and wellbeing needs of LGBT Queenslanders.*' Central to this strategic direction is Gay Men's and Aboriginal & Torres Strait Islander HIV and Hep C Prevention, and Sexual Health Promotion.[7]

Whilst another stated strategic direction is 'Leading Voice on LGBT Issues', this is in the context of representing the needs of LGBT Queenslanders on LGBT health, wellbeing and related human rights issues.[8] The United Nations supports this approach, and has a strategic direction for the global HIV response 'Advancing human rights and gender equality for the HIV response'. This strategic direction has, at its core, 'protection human rights in the context of HIV – including the rights of ... men who have sex with men.'[9]

QAHC have also published a 'Hierarchy of Outcomes' document which depicts how a range of health promotion activities (including 'Promotion of gay-friendly healthy public policy and general community environment') all contribute to the desired health outcome of 'Prevention of HIV, STI and Hep C infections in Gay Men / Men who have Sex with Men.'[10]

1.5 'Grants had, until now, been channelled through the Queensland Association for Healthier Communities'

The organisation is actually named the Queensland Association for *Healthy* (not Healthier) Communities. A minor and inconsequential error, I confess, but if you were about to have your life-support cut I don't think you would care to be called Mr Springboard.

2.0 Questions

I have a number of questions arising from your media statement.

2.1 Ministerial Advisory Committee on HIV/AIDS ('the Committee')

- What form will the Committee take? Will it be purely advisory as to best methods of service delivery? Will it be involved in service delivery itself?
- What will be the membership of the Committee? Who will appoint the members?

2.2 QAHC / On-going service delivery

- At what date will funding to QAHC be cut? Will it be before the establishment of the Committee?
- If funding does cease prior to the establishment of the Committee, and/or if the Committee is not involved in the delivery of front-line services, who will provide the range of services currently provided by QAHC?

2.3 Community based HIV prevention

- The United Nations highlights in numerous publications the importance of community involvement and engagement in HIV prevention, particularly amongst those segments highest at risk.[11] What evidence do you possess that a government funded bureaucracy and an

[7] Ibid 5.

[8] Ibid.

[9] UNAIDS, *2011-2015 Strategy: Getting to Zero* (2010) 10. <http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/JC2034_UNAIDS_Strategy_en.pdf>

[10] QAHC, *Hierarchy of Outcomes for QAHC*. <http://www.qahc.org.au/files/shared/docs/Outcomes.pdf>

[11] See Appendix 2 for examples.

immediate cessation of funding of (and thus, provision of services by) a community organisation is an effective response?

2.4 HIV prevention in the context of LGBT health

- Will the LGBT community be provided specific representation on the Committee?
- Given:
  - decisions one makes about their sex life is influenced not only by one's knowledge of sexual health, but also by the environment one finds themself in;
  - that the environment of LGBT includes such issues as drugs and alcohol, mental health, relationship issues, stigma and discrimination; and
  - the United Nations supports the involvement of community organisations in the delivery of HIV prevention and other programs[12]

  why do you believe the immediate defunding of QAHC is an appropriate response?

3.0 Requests and Conclusion

Following on from these points, I therefore request –

- The questions posed in section 2 of this letter are responded to;
- A comprehensive strategy to combat increasing HIV notification rates in Queensland be developed based on best available information, including the importance of community based organisations and the holistic health and well-being requirements for the LGBT community;
- The decision to defund QAHC be reversed; and
- A media statement be released by your department highlighting any and all factual inaccuracies and misrepresentations contained within your media statement of 20 May 2012.

I have courtesy copied a number of interested parties, including the Queensland Premier, the Qld Opposition Spokesperson for Health, Federal Health Minister, QHAC, various LGBT advocacy groups and a number of media outlets. A full list of these recipients is included in Appendix 4.

Thank you for taking the time to read and consider my letter, and I look forward to hearing from you at your earliest convenience.

Regards

Mathew Burke

[12] See Appendix 3 for examples.

Appendix 1: Exhibits

Exhibit 1: Notifications and notification rate of new HIV diagnosis, by whether first diagnosed in Queensland or overseas

Year	HIV notifications			HIV notification rates**		
	Qld†	Overseas‡	Total^	Qld†	Overseas‡	Total^
1984	21	0	*21*	0.8	0.0	0.8
1985	151	1	*152*	5.9	0.0	5.9
1986	127	5	*132*	4.8	0.2	5.0
1987	120	1	*121*	4.5	0.0	4.5
1988	106	0	*106*	3.9	0.0	3.9
1989	138	3	*141*	4.9	0.1	5.0
1990	118	8	*126*	4.1	0.3	4.3
1991	119	8	*127*	4.0	0.3	4.3
1992	95	6	*101*	3.1	0.2	4.0
1993	84	11	*95*	2.7	0.4	3.1
1994	110	9	*119*	3.5	0.3	3.7
1995	99	14	*113*	3.0	0.4	3.5
1996	119	11	*130*	3.6	0.3	3.9
1997	96	19	*115*	2.8	0.6	3.4
1998	86	15	*101*	2.5	0.4	2.9
1999	102	15	*117*	2.9	0.4	3.3
2000	96	17	*113*	2.7	0.5	3.2
2001	96	8	*104*	2.6	0.2	2.9
2002	117	13	*130*	3.2	0.4	3.5
2003	114	12	*126*	3.0	0.3	3.3
2004	137	19	*156*	3.5	0.5	4.0
2005	148	16	*164*	3.7	0.4	4.1
2006	143	24	*167*	3.5	0.6	4.1
2007	165	29	*194*	3.9	0.7	4.6
2008	166	29	*195*	3.9	0.7	4.5
2009	182	25	*207*	4.1	0.6	4.7
2010#	206	33	*239*	4.7	0.7	5.4
Total	**3261**	**351**	***3612***	**n/a**	**n/a**	**n/a**

** Rates are calculated per 100,000 population using Estimated Resident Population (ERP) figures from the Australian Bureau of Statistics, cat. no. 3235.0

\# Rates** for 2010 are calculated using Estimated Resident Population figures for 2009

† First diagnosis was in Queensland

‡ First diagnosis was overseas, although first diagnosis in Australia was in Queensland

^ Total of first diagnoses of HIV in Queensland and first diagnoses of HIV overseas. This definition is used by the National Centre for HIV Epidemiology and Clinical Research (NCHECR) as total first diagnoses.

n/a Not applicable

Source: Queensland Government (Queensland Health), *2010 HIV/AIDS Report: Epidemiology and Surveillance* (September 2011) 28 (Table 3). <http://www.health.qld.gov.au/sexhealth/documents/hivaidsannualreport.pdf>

Note: Highlights have been added by author.

Exhibit 2: Percentage of notifications of new HIV diagnosis by sex and risk exposure, Queensland, 2005-2010

Risk exposure	Year						
	2005	2006	2007	2008	2009	2005-2009	2010
Males							
Men who have sex with men	78.8	79.8	79.5	76.8	78.0	78.5	74.7
Sexual contact only with person of same sex	59.9	66.1	65.1	58.5	67.9	63.6	60.9
Sexual contact with person of same sex and injecting drug use	8.8	4.8	3.4	6.3	1.9	4.9	1.7
Sexual contact with both sexes	8.0	8.1	10.3	11.3	7.5	9.0	9.8
Sexual contact with both sexes and injecting drug use	2.2	0.8	0.7	0.7	0.6	1.0	2.3
Injecting drug use (only)	3.6	2.4	2.1	1.4	4.4	0.0	1.7
Heterosexual	5.1	5.6	8.2	6.3	5.0	6.1	8.6
Contact only with person(s) of opposite sex**	0.0	0.0	0.0	0.7	0.0	0.1	0.0
Contact only with person(s) of opposite sex and injecting drug use	0.0	0.0	0.0	0.0	0.0	0.0	0.6
Contact with a person from a "high prevalence country" #	5.1	5.6	6.8	4.9	3.1	5.1	7.5
Other contact	0.0	0.0	1.4	0.7	1.9	0.8	0.6
Person originating from a "high prevalence country" #	2.9	2.4	4.1	5.6	5.0	4.1	6.3
Other/undetermined	9.5	9.7	6.2	9.9	7.5	8.5	8.6
Maternal exposure	0.0	0.8	0.0	0.7	0.6	0.4	0.0
Other type of exposure	0.7	0.0	0.0	0.0	0.0	0.1	0.6
Not interviewed/unknown	8.8	8.9	6.2	9.2	6.9	7.9	8.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Females							
Injecting drug use (only)	0.0	0.0	10.5	4.5	0.0	3.3	3.1
Heterosexual	60.0	33.3	47.4	27.3	50.0	41.8	28.1
Contact only with person/s of opposite sex**	0.0	0.0	15.8	4.5	18.2	8.8	0.0
Contact only with person(s) of opposite sex and injecting drug use	10.0	11.1	5.3	4.5	0.0	5.5	6.3
Contact with a bisexual male	10.0	0.0	5.3	4.5	4.5	4.4	0.0
Contact with a bisexual male and injecting drug use	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Contact with a person from a "high prevalence country" #	40.0	16.7	5.3	9.1	13.6	14.3	18.8
Contact with a person from a "high prevalence country" # and injecting drug	0.0	5.6	0.0	0.0	0.0	1.1	0.0
Other contact	0.0	0.0	15.8	4.5	13.6	7.7	3.1
Person originating from a "high prevalence country" #	30.0	55.6	36.8	40.9	45.5	42.9	59.4
Other/undetermined	10.0	11.1	5.3	27.3	4.5	12.1	9.4
Maternal exposure	0.0	5.6	0.0	4.5	4.5	3.3	3.1
Other type of exposure	0.0	0.0	5.3	0.0	0.0	1.1	0.0
Not interviewed/unknown	10.0	5.6	0.0	22.7	0.0	7.7	6.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
People							
Men who have sex with men	73.5	70.2	70.3	66.5	68.5	69.7	63.1
Sexual contact only with person of same sex	55.8	58.2	57.6	50.6	59.7	56.4	51.5
Sexual contact with person of same sex and injecting drug use	8.2	4.3	3.0	5.5	1.7	4.4	1.5
Sexual contact with both sexes	7.5	7.1	9.1	9.8	6.6	8.0	8.3
Sexual contact with both sexes and injecting drug use	2.0	0.7	0.6	0.6	0.6	0.9	1.9
Injecting drug use (only)	3.4	2.1	3.0	1.8	3.9	2.9	1.9
Heterosexual	8.8	8.5	12.7	9.1	10.5	10.0	11.7
Contact only with person/s of opposite sex**	0.0	0.0	1.8	1.2	2.2	1.1	0.0
Contact only with person(s) of opposite sex and injecting drug use	0.7	1.4	0.6	0.6	0.0	0.6	1.5
Contact with a bisexual male	0.7	0.0	0.6	0.6	0.6	0.5	0.0
Contact with a bisexual male and injecting drug use	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Contact with a person from a "high prevalence country" #	7.5	7.1	6.7	5.5	4.4	6.1	9.2
Oher contact	0.0	0.0	3.0	1.2	3.3	1.6	1.0
Person originating from a "high prevalence country" #	4.8	9.2	7.9	10.4	9.9	8.5	14.6
Other/undetermined	9.5	9.9	6.1	12.2	7.2	8.9	8.7
Maternal exposure	0.0	1.4	0.0	1.2	1.1	0.8	0.5
Other type of exposure	0.7	0.0	0.6	0.0	0.0	0.3	0.5

Source: Queensland Government (Queensland Health), *2010 HIV/AIDS Report: Epidemiology and Surveillance* (September 2011) 41 (Table 19) <http://www.health.qld.gov.au/sexhealth/documents/hivaidsannualreport.pdf>

Note: Highlights have been added by author.

Exhibit 3: Notification rate (per 100,000 population) of new HIV diagnosis by Indigenous status and sex, Queensland, 2005-2010

Indigenous status	Year						
	2005	2006	2007	2008	2009	2005-2009	2010
Males							
Indigenous	8.5	6.9	5.4	4.0	7.7	6.5	6.4
Non-Indigenous	6.9	6.1	7.0	6.8	7.0	6.8	7.9
Unknown	0.0	0.0	0.0	0.0	0.2	0.0	0.0
Total	6.9	6.1	7.0	6.7	7.2	6.8	7.9
Females							
Indigenous	1.4	0.0	1.3	0.0	1.3	0.8	2.5
Non-Indigenous	0.5	0.9	0.9	1.1	1.0	0.9	1.4
Unknown	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.5	0.9	0.9	1.0	1.0	0.9	1.4
People							
Indigenous	4.9	3.5	3.4	2.0	4.5	3.6	4.5
Non-Indigenous	3.7	3.5	4.0	3.9	4.0	3.8	4.6
Unknown	0.0	0.0	0.0	0.0	0.1	0.0	0.0
Total	3.7	3.5	3.9	3.9	4.1	3.8	4.7

Source: Queensland Government (Queensland Health), *2010 HIV/AIDS Report: Epidemiology and Surveillance* (September 2011) 38 (Table 15) <http://www.health.qld.gov.au/sexhealth/documents/hivaidsannualreport.pdf>

Note: Highlights have been added by author.

Appendix 2: Examples of United Nations support of community organisations in the prevention of HIV

Declaration on HIV and AIDS[13]

40. Recognize that close cooperation with people living with HIV and populations at higher risk of HIV infection will facilitate the achievement of a more effective HIV and AIDS response, and emphasize that people living with and affected by HIV, including their families, should enjoy equal participation in social, economic and cultural activities, without prejudice and discrimination, and that they should have equal access to health care and community support as all members of the community.

44. Recognize the role that community organizations play, including those run by people living with HIV, in sustaining national and local HIV and AIDS responses, reaching all people living with HIV, delivering prevention, treatment, care and support services and strengthening health systems, in particular the primary healthcare approach.

UN AIDS 2011-2015 Strategic Plan[14]

- Effective prevention depends on such engagement and in involving the groups at higher risk in designing and delivering programs.[15]

- Partner with networks of people living with HIV and other key populations in the context of peer-led, rights based initiatives, to increase voluntary HIV testing and counselling, treatment adherence and HIV and human rights literacy and protection.[16]

UN AIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People[17]

- Action is required by a broad range of partners, simultaneously addressing both short and long-term needs and opportunities. The most effective and sustainable responses to HIV among men who have sex with men and transgender people are built on *synergies between many actors, including affected communities, allies,* governments, the private sector and the UN family.[18]

[13] *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS,* GA Res 65/277, 65th session, 2011. <http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf>

[14] UNAIDS, above n 9.

[15] Ibid 34.

[16] Ibid 35.

[17] UNAIDS, *UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People* (2009). <http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/report/2009/jc1720_action_framework_msm_en.pdf>

[18] Ibid 6.

Appendix 3: Examples of United Nations support of community organisations in the prevention of HIV for LGBT persons

World Health Organisation ('WHO') Meeting Report[19]

- Addressing the HIV and STI epidemics among MSM and transgender people cannot be achieved by the health sector alone, though it plays a crucial role. It requires partnerships and engagement both across sectors (particularly with the legal and education sectors) and, *crucially, with the MSM and transgender communities.*[20]
- *[T]he need to take a holistic approach* to providing prevention and care services for MSM and transgender people ... [with] widespread recognition that provision of these services [HIV prevention and care] alone will not adequately meet the health needs of MSM and transgender people.[21]
- Key recommendation for the health sector to achieve improvements in service delivery include –
    - Ensure that governance of health sector initiatives includes representatives from civil society organizations working with MSM and transgender people.
    - Build and strengthen coalitions among civil society and other key stakeholders to address the sexual health needs of MSM, transgender people and their partners.
    - Build on local expertise, and involve both experts and end-users of services in adapting priority interventions and models of service delivery to address the specific local needs and situation.
    - Incorporate MSM and transgender issues into the training curriculum of health-care professionals, e.g. medical and nursing schools.[22]

UN AIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People[23]

- Ensuring the participation of men who have sex with men and transgender people in the planning, implementation and review of HIV-related responses, including the support of nongovernmental and community-based organizations, including organizations of people living with HIV.[24]

[19] WHO, *Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgendered populations: Report of a technical consultation* (2008). <http://www.who.int/hiv/pub/populations/msm_mreport_2008.pdf>

[20] Ibid 22.

[21] Ibid 23.

[22] Ibid 24.

[23] UNAIDS, Above n 17.

[24] Ibid 10.

Appendix 4: List of courtesy copies distributed[25]

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